STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445288	A. BUILDING _____ B. WING _____	12/03/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUNTSVILLE MANOR	287 BAKER STREET HUNTSVILLE, TN 37756

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A recertification survey and complaint investigation #34977 were completed on December 1, 2014, through December 3, 2014, at Huntsville Manor. No deficiencies were cited related to complaint investigation #34977 under 42 CFR Part 483 Requirements for Long Term Care Facilities.	F 000		
F 164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.	F 164	F164 483.10(e), 483.75(I)(4) Personal Privacy/Confidentiality of Records **Corrective action(s) accomplished for those residents found to have been affected by the deficient practice:** 1. On 12/2/14 at 1:10 p.m. initiated transfer of rooms for resident #24. Transfer completed by Social Service Director. Completion date:: 12/2/14 **Identify other residents having the potential to be affected by the same deficient practice and what corrective action taken:** 2 The Social Service Director completed a 100% facility audit of rooms to ensure that we were in compliance of our room assignment policy. Completion date: 12/3/14 **Measures/systematic changes put in place to ensure that the deficient practice does not recur;** 3 In-service began on December 3, 2014 by Administrator and Risk Manager on "Room Assignment Policy" with Nursing and C.N.A. staff, Social Service Director, and Admissions Director.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Laura Pittman	Administrator	12/23/14

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEC 26 2014

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F 164	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on medical record review, facility policy review, observation, and interview, the facility failed to ensure privacy was maintained for two (#126, #26) residents of thirty-four residents reviewed. The findings included: Resident #126 was admitted to the facility on September 23, 2014, with diagnoses including Chronic Pain, Hypertension, General Osteoarthrosis, Anxiety, Dementia, and Depression. Medical record review of the Admission Minimum Data Set (MDS) dated September 30, 2014, revealed the resident was independent in cognitve skills for daily decision making. Observation on December 2, 2014, at 8:40 a.m., of the resident's room, revealed a bathroom between the resident's room and a male resident's room. Continued observation revealed Resident #126 and #26 shared a room together. Review of facility policy, Room Assignments, revealed "...A room assignment is made on the basis of the first available bed that satisfies the resident's medical/treatment requirements. The following factors shall be considered when making a room assignment...The sex of the resident..." Interview with Resident #126 in the resident's room on December 2, 2014, at 8:40 a.m.,	F 164	Completion date: Room Assignment Policy has been added to New Employee Orientation. Completion date: Social Service Director will conduct daily rounds that will include review of Room Assignment Policy being implemented appropriately. **Monitoring of corrective action to ensure the deficient practice will not recur;** 4. Social Service Director will conduct rounds 2x a week that for next 4 weeks that will include review of Room Assignment Policy being implemented appropriately. Review of the rounds by Social Service Director will be added to the daily SWOT meeting for review and Risk Manager will review in his absence. Failure to adhere to facility policy will be considered a violation. Violations will result	12/26/14 12/4/14

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F 164	Continued From page 2 confirmed, "I don't like it." Continued interview confirmed the male resident had opened the door while resident #126 was in the bathroom. Resident #26 was admitted to the facility on July 27, 2012, with diagnoses of Diabetes Mellitus Type II, Abnormality of Gait, Lack of Coordination, Chronic Pain, Insomnia, and Person History of Falls. Medical record review of the quarterly Minimum Data Set (MDS) dated August 25, 2014, indicated the resident was moderately cognitively impaired. Interview with Resident #26 on December 1, 2014, at 1:30 p.m., in the resident's room, revealed the resident and the resident's roommate (#126), had to share a bathroom with a male, which was considered by the resident to be "...embarrassing and not very dignified..." Interview with the Administrator on December 2, 2014, at 2:10 p.m., in the conference room confirmed the sharing of bathrooms is a privacy issue.	F 164	in disciplinary action in accordance with the facility progressive disciplinary policy. Report of overall findings and subsequent disciplinary action, if applicable, will be reported to the facility Quality Assurance (QA) Committee (consisting of DON, Medical Director, ADON, NHA, Risk Manager, MDSC, Pharmacy Consultant, Registered Dietician, Wound Care Nurse, SSD) to review the need for continued intervention or amendment of plan. 5. Completion date:	12/31/14
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.	F 323	F323 483.25(h) Free of Accident Hazards/Supervision/Devices **Corrective action(s) accomplished for those residents found to have been affected by the deficient practice:** 1. Resident #92 transferred to Cumberland Village on 11/6/14. Completion date: **Identify other residents having the potential to be affected by the same deficient practice and what corrective action taken:** 2. Risk Manager will conduct 100% facility audit to determine patients and/or residents have adequate supervision and/or assistance devices to prevent accidents if needed.	11/6/14

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F 323	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to provide supervision for one (#92) resident of five residents reviewed for accidents of thirty-four residents reviewed. The findings included: Resident #92 was admitted to the facility on February 21, 2014, with diagnoses including Alzheimer's Disease, Dementia, Hypertension, and Depression. Medical record review of the fall risk assessment dated October 29, 2014, revealed the resident was at high risk for falls. Medical record review of the Nurse's Notes dated October 29, 2014, revealed "...called to room...upon entering found residents both [#6 and #92] on floor...[resident #6] stated "...got tangled up in each other feet and fell together... [no] injuries noted to either resident..." Review of the facility investigation for (resident #6) revealed "...[resident #6] and another resident [#92] were noted on floor in [resident #6] room...no injuries noted at time of fall...[resident #6] stated that the other resident had come into...room and [resident #6] tried to divert [resident #92] out and the other resident had pushed [resident #6] and they both fell...New intervention; Stop sign to door..." Interview with the Director of Nursing on December 2, 2014, at 1:30 p.m., in the conference room confirmed no supervision had	F 323	Patients and/or residents identified will have their care plan reviewed and updated. Completion date:	12/26/14
			Measures/systematic changes put in place to ensure that the deficient practice does not recur; 3. In-service began on December 23, 2014 by Risk Manager Manager on "Safety & Supervision of Residents Policy" with all staff. Completion date:	12/26/14
			Risk Manager will add the "Safety & Supervision of Residents Policy" to Employee Orientation. Completion date:	12/22/14
			Monitoring of corrective action to ensure the deficient practice will not recur; 4. Risk Manager and Social Service Director will conduct rounds 2x a week for the next 4 weeks to ensure that appropriate supervision is in place for anyone identified as a "Resident Safety & Supervision Concern". Review of the rounds by Risk Manager & Social Service Director will be added to the daily SWOT meeting for review.	

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F 323	Continued From page 4 been provided for resident #92 resulting in a fall for resident #6.	F 323	Failure to adhere to facility policy will be considered a violation. Violations will result in disciplinary action in accordance with the facility progressive disciplinary policy. Report of overall findings and subsequent disciplinary action, if applicable, will be reported to the facility Quality Assurance (QA) Committee (consisting of DON, Medical Director, ADON, NHA, Risk Manager, MDSC, Pharmacy Consultant, Registered Dietician, Wound Care Nurse, SSD) to review the need for continued intervention or amendment of plan. 5. Completion date:	12/31/14
F 520 SS=D	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on facility record review and interview, the facility failed to provide evidence of a physician's active participation in the facility's Quality Assurance (QA) process.	F 520	F520 483.75(o)(1) QAA Committee-Members/Meet Quarterly/Plans **Corrective action(s) accomplished for those residents found to have been affected by the deficient practice:** 1. Medical Director attended QAA meeting on December 16, 2014. Signature sheet obtained for records. Completion date: 12/16/14 **Identify other residents having the potential to be affected by the same deficient practice and what corrective action taken:** 2. There is only 1 Medical Director/Physician on staff. Completion date: 12/26/14	

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F 520	Continued From page 5 The findings included: Record review of the QA Committee list of members revealed the committee included the Medical Director (MD), the Director of Nursing, the Pharmacy Consultant, the Registered Dietician, seven department heads/managers, and the Charge Nurse. Record review of the 2014 QA Committee meeting sign-in-sheets and meeting minutes notes revealed the committee met on January 14, 2014, February 6, 2014, March 19, 2014, May 30, 2014, July 25, 2014, August 11, 2014, September 3, 2014, October 31, 2014, and November 25, 2014. Continued review revealed the MD attended one QA committee meeting on February 6, 2014, and signed off as having reviewed the QA Committee meeting notes for the meetings conducted on July 25, 2014 and August 11, 2014, which the MD did not attend. Interview with the Administrator on December 3, 2014, at 1:00 p.m., in the Administrator's office confirmed the QA Committee met monthly and as needed to address identified issues, and the MD only attended the February 6, 2014, QA meeting and signed off on two of the QA meetings the MD did not attend.	F 520	**Measures/systematic changes put in place to ensure that the deficient practice does not recur;** 3. In-service/review conducted by the Administrator with Medical Director on State regulation 520 Quality Assessment and Assurance and Current Medical Director Contract/Agreement. Completion date: Administrator and Medical Director will coordinator time and date for QAA meetings to help with the attendance of Medical Director. **Monitoring of corrective action to ensure the deficient practice will not recur;** 4. Administrator will track Physician attendance for QAA meetings and maintain a tracking log. (ongoing) Failure to adhere to regulations and contract agreement can result in termination of contract. Report of overall findings and subsequent disciplinary action, if applicable, will be reported to the facility Quality Assurance (QA) Committee (consisting of DON, Medical Director, ADON, NHA, Risk Manager, MDSC, Pharmacy Consultant, Registered Dietician, Wound Care Nurse, SSD) to review the need for continued intervention or amendment of plan. 5. Completion date:	12/26/14 12/26/14